Specific Site Analysis Test Requisition Form - Page 1 of 2
(Known Familial Alteration Analysis)

Aliso Viejo, CA 92656 USA
Toll Free: 866.262.7943 | Fax: 949.900.5501 | ambrygen.com

COMPLETE ENTIRE FORM TO AVOID DELAYS

PATIENT INFORMATION

Name (Last, First, MI) | Date of Birth (MM/DD/YY) | Date of Death (If applicable) | Phone Number/Email

Address | City | State | Zip | Biological Sex ☐F ☐M | Ethnicity: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Jewish (Ashkenazi) ☐Portuguese ☐Other:

SPECIMEN INFORMATION* (For phlebotomy service, select all services you are requesting)

Type(s) ☐Blood (EDTA preferred) ☐Saliva ☐DNA, Source: ☐Other: | ☐Personal history of allogenic bone marrow or peripheral stem cell transplant

Collection Date | Specimen ID | Medical Record #

**Blood or saliva from patients with active/recent hematological disease will undergo additional review and may not be accepted in some cases. For these, cultured fibroblasts or fresh/fresh frozen normal tissue are preferred. See ambrygen.com/specimen-requirements for details.*

Phlebotomy Services Request: ☐Phlebotomy draw ☐Insurance preverification first ☐Send kit to patient^
^As the patient's clinician, I am unaware of any potential for complication or difficulty in drawing blood for the listed patient(s). I understand that the phlebotomist has full authority to refuse to draw any patient if the safety of the phlebotomist and/or patient(s) are in question.

INDICATION(S) FOR TESTING

ICD-10 code(s):

PRENATAL SAMPLES ONLY

Sample type: ☐ Direct CVS ☐ Cultured CVS ☐ Cultured amnio ☐ POC ☐ Cultured POC | Gestational age at sample collection

ORDERING LICENSED PROVIDER/SENDING FACILITY (Each listed person will receive a copy of the report)

Facility Name (Facility Code) | Address | City | State /Country | Zip | Phone

Ordering Licensed Provider Name (Last, First)(Code) | NPI# | Phone | Fax/Email

ADDITIONAL RESULTS RECIPIENTS

Genetic Counselor or Other Medical Provider Name (Last, First) (Code) | Phone/Fax/Email

Genetic Counselor or Other Medical Provider Name (Last, First) (Code) | Phone/Fax/Email

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING
The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate consent. I confirm that testing is medically necessary and that test results may impact medical management for the patient. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the attached letter of medical necessity (unless this box is checked ☐).

Signature Required for Processing Medical Professional Signature: Date:

☐ INSURANCE BILLING (Include copy of both sides of insurance card)

Patient Relation to Policy Holder? ☐Self ☐Spouse ☐Child | Name and DOB of Policy Holder (if not self)

Insurance Company | Policy # | HMO Auth #

Ambry Genetics preverifies insurance coverage and will contact the patient after the patient's sample is received if the out-of-pocket amount for testing is estimated to exceed (*Nothing checked defaults to >$100*):
☐ $100 ☐ Any amount ☐ Other $

☐ Hold order pending patient contact and approval of payment terms regarding out-of-pocket.

Patient preferred method of contact regarding out-of-pocket amount: ☐ Email ☐ Phone

☐ INSTITUTIONAL BILLING

Facility Name | ☐ *Send invoice to facility address above*

Address

Contact Name

Phone Number | E-mail/Fax

☐ PATIENT PAYMENT

☐Check (Payable to Ambry Genetics)
☐Credit Card (Call 949-900-5795)

Patient Acknowledgement: I acknowledge that the information provided by me is true and correct. For direct insurance billing: I authorize my insurance benefits to be paid directly to Ambry Genetics Corporation (Ambry), authorize Ambry to release medical information concerning my testing to my insurer, to be my designated representative for purposes of appealing any denial of benefits as needed and to request additional medical records for this purpose. I understand that I am financially responsible for any amounts not covered by my insurer and responsible for sending Ambry money received from my health insurance company.
For patient payment by credit card: I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for **Ambry's E.P.I.C. Program**, please provide the total annual gross household income: $________ and the number of family members in the household supported by the listed income: ________. I authorize Ambry Genetics Corporation to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.

FOR NY RESIDENTS:
☐ I am a New York resident and I give Ambry Genetics permission to store my sample for longer than 60 days. **NOTE:** If left blank, consent is interpreted as "NO".

Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent: Date:

Ambry Genetics®

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Patient Name: ______________________ DOB: __________

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SPECIFIC SITE ANALYSIS

Positive control: ☐ Sent ☐ To be sent ☐ Not available ☐ Available at Ambry, accession #:

The following will be requested when ordering known mutation analysis for a mutation identified in an outside laboratory:

1. Proband report (mandatory)
2. Positive control (recommended; required for prenatal testing)

ACMG guidelines, CAP and CLIA regulatory provisions recommend use of a positive control to provide evidence of amplification when interrogating a specific sequence alteration. It is recommended that individuals for a known genotype for the locus tested be included as a positive control to ensure assay performance.

☐ 5648 Specific Site Analysis (SSA)

ALTERATION TO BE TESTED

Gene	Alteration
Gene 1	Alteration 1
Gene 2	Alteration 2
Gene 3	Alteration 3
Gene 4	Alteration 4

PATIENT CLINICAL INFORMATION

☐ Healthy ☐ Affected/Symptomatic, age at diagnosis:

Please list relevant clinical findings with ICD-10 codes:

PREVIOUS TEST HISTORY (Please include copy of test results if performed at another laboratory)

Previously Detected Alteration(s)	Gene Name	Testing Lab

Patient previously tested at Ambry? ☐ Yes ☐ No Family previously tested at Ambry? ☐ Yes ☐ No

Name	Date of Birth (MM/DD/YY)	Relation

FOR PRENATAL SPECIMENS ONLY: MATERNAL CELL CONTAMINATION (Required for fetal specimens)

☐ 1260 MCC for amniotic fluid culture or CVS (run concurrently with test) ☐ 1262 MCC Reference for maternal blood sample (No Charge)